Commentary

Medical Shortage Designation

A Federal Intervention That Works

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In too many cases, the skills and knowledge of health professionals are not available to the most vulnerable groups in society. In numerous areas in the United States, basic primary health services do not exist or are extremely limited. Through the Health Resources and Services Administration's Bureau of Primary Health Care (BPHC), the federal government has sought to fill this gap by using a number of different interventions, or approaches, designed to increase access to primary health care and, ultimately, to improve the health status of underserved populations.

A lack of access to primary health care may be due to a shortage of health care professionals or the absence of an available and accessible system of care. To remedy these inadequacies, several federal, state, and local programs have been implemented to improve access to primary health services. Some of these approaches use financial incentives; others attempt to recruit professionals to underserved areas through various enticements; yet other approaches focus on the development of systems. Regardless of the adopted intervention, it is critical that program officials develop a method for targeting resources to the most needy communities in the most efficient manner.

The decision to place limited resources in a community is based on several factors. At the federal level, these factors may include legislative authority, the intent of the legislation, regulation, and guidance. Federal departments use a variety of mechanisms to direct the flow of resources to communities. In some cases, resources are allocated regionally or to states for distribution; in others, the resources are awarded directly to the community or target group. The critical component in the allocation of federal resources is the legislative authority that created the program.

The BPHC administers several programs that have specific target audiences. These activities and the method for distributing the resources are based on both the statute and the legislative intent. To illustrate this concept, we discuss two methods for distributing federal resources.

The BPHC provides grants for the support of community-based comprehensive primary care services. To be eligible to apply for this support, a community must provide information on the degree of medical underservice in the area where the services are to be provided. According to federal regulation, medical underservice is calculated by several factors in a community, such as the percentage of the population at or below the poverty level, infant mortality, the number of persons 65 years of age or older, and the ratio of primary care professionals (physicians) to the population. The capability of the requesting organization or group to provide comprehensive community-based primary care services is considered equally important. A measure of a community's need for primary care services is the foundation for a federal designation that establishes the community as a medically underserved area or as having a medically underserved population. A prudent use of public funds is a consideration before the decision to distribute resources to a community.

The other method for resource distribution is an intervention that addresses the need for primary care providers. This intervention was established by Congress to alleviate shortages of primary medical care professionals. Primary medical care professionals are defined as physicians in family practice, general internal medicine, general pediatrics, and obstetrics and gynecology; nurse practitioners; physician assistants; and certified nurse midwives. The statute clearly identifies those physicians classified as primary care. To some extent, physicians in other medical specialties may provide some form of primary care; however, their specific training is in their subspecialty. The framers of the statute thought that the specialties described in the legislation best represented primary medical care.

Specific criteria have been developed to identify communities experiencing shortages of primary medical care providers. Communities, populations, or facilities facing such shortages may apply for recruitment assistance. One type of assistance consists of incentives for primary care professionals to serve in underserved areas. Communities seeking this assistance must be designated as a health professional shortage area (HPSA). In the case of primary medical care HPSAs, the designation is based on the number of primary care physicians available to serve the area or the specific population. Other factors such as the percentages of persons at or below the poverty level, infant mortality, or low birth weight and distance or time to the

(Arrindell ER, Ruck JM: Medical shortage designation—A federal intervention that works. West J Med 1996; 164:537-538)

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nearest contiguous source of primary care are included in the analysis for evaluating a designation request.

Issues have been raised concerning the exclusion of nurse practitioners, physician assistants, and certified nurse midwives from the calculation of primary medical care professional ratios. The basis for this exclusion entails practice regulations that vary widely from state to state in the degree of latitude offered these providers. For example, in some states these practitioners have prescriptive authority whereas in other states they do not. Physicians maintaining an unrestricted license to practice medicine can enjoy a relatively consistent practice pattern across state lines; this is not the case for other primary care professionals. They must have the mobility to transfer nationally to fill practice gaps. In addition, the lack of uniformity in state requirements for physician assistants, nurse practitioners, and certified nurse midwives currently precludes the development of an appropriate method for enumerating these providers.

The national criteria established for the two programs were based on the legislative authority and intent as discussed in the statute. The statute did not imply any expanded use of the criteria; however, there was no prohibition placed on other federal, state, or local programs concerning the use of these criteria. As a result, federal programs have been developed that use these criteria as part of their method for allocating resources. Implementation and oversight of some of these programs, however, rest with other federal agencies.

Requests for designation are generated at the state and local levels. The responsibility for collecting data and preparing the request is borne by the applicant. In submitting a request for a designation, an applicant—usually the state health department—provides demographic data and information on the number of primary care physicians serving the area or population. The demographic data are compared with census data and other national data for the proposed service area. This information is compared with the American Medical Association's (AMA) and the American Osteopathic Association's (AOA) listings of physicians. These sources are not comprehensive listings of practicing primary care physicians; rather, they are used as guides in verifying information provided by the applicant. Discrepancies in information provided within the designation request and the AMA/AOA listings of physician are resolved between the Division of Shortage Designation and the applicant. The Division of Shortage Designation, which is in the BPHC, is charged with overseeing the designation process.

For more information on the federal shortage designation process, contact the Division of Shortage Designation at (301) 594-0816.

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Commentary

Are You Being Counted?

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Are physicians being counted accurately? Physician demographic data are used in a wide variety of ways to decide what state and federal programs to pump up, leave alone, or cut back. Grants of almost unlimited variety depend on shortage designations.

In California the Office of Statewide Health Planning and Development (OSHPD), headed by David Werdegar, MD, MPH, makes recommendations to the Division of Shortage Designation, which is part of the US Department of Health and Human Services' Bureau of Primary Care. These recommendations are sometimes voted on by a commission that works closely with OSHPD.

Federally qualified health clinics and rural health clinics, both hospital-based and free-standing, depend heavily on shortage designations. These clinics are compensated using cost-based accounting. Free-standing rural health clinics have a cap of about $57 per visit. Hospital-based rural health clinics have no cap, and information contained in one hospital's disclosure report indicates that it may be getting about $136 per visit. Federally qualified health clinics have two caps, one urban and one rural. Recently the urban caps have been around $88 per visit, and the rural caps have been $76. If a county has been designated a metropolitan statistical area, however, federally qualified health clinics in communities as small as less than 5,000 people have been able to get paid at the higher cap. The payment level always seems to approach the cap when there is one.

(Feehan EB: Are you being counted? West J Med 1996; 164:538-539)

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